

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035427

FILED VS SEP 19 1960

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 113

STATE FILE NUMBER

INDEXED

|   |  |   |   |  |   |  |  |
|---|--|---|---|--|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Linn</u><br>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u> Length of stay in 1b <u>31 yrs</u><br>c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Brookfield Nursing Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |   |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> COUNTY <u>Linn</u><br>c. CITY OR TOWN <u>Brookfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br>d. STREET ADDRESS (If outside, give location) <u>523 Macon Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) First <u>MAY</u> Middle <u>McCUNE</u> Last   |  |   | <b>4. DATE OF DEATH</b> Month <u>Sept.</u> Day <u>10,</u> Year <u>1960</u>                          |  |   |  |  |
| <b>5. SEX</b> <u>F</u>  | <b>6. COLOR OR RACE</b> <u>W</u>   | <b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | <b>8. DATE OF BIRTH</b> <u>4-12-1880</u>  | <b>9. AGE (last birthday)</b> <u>80</u>  | <b>IF UNDER 1 YEAR</b> Months <u>    </u> Days <u>    </u>              | <b>IF UNDER 24 HR</b> Hours <u>    </u> Min. <u>    </u> |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>  |   | <b>11. BIRTHPLACE</b> (City and state or country) <u>Anabel, Macon Co., Mo.</u>  |   | <b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>            |  |
| <b>13a. FATHER'S NAME</b> <u>William C. White</u>   |  |   | <b>13b. MOTHER'S MAIDEN NAME</b> <u>Sallie Grace Gresham</u>  |  | <b>14. NAME OF HUSBAND OR WIFE</b> <u>Joseph V. McCune</u>              |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>   |  | <b>16. SOCIAL SECURITY NO.</b> <u>None</u>  |   | <b>17. INFORMANT</b> <u>C. W. Shay, Quincy, Ill.</u> Address   |   |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>C. Cerebral Vascular Accident -</u><br>DUE TO (b) <u>Arteriosclerotic heart disease</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.                         |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 wks.</u><br><u>5 yrs.</u>      |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>None</u>  |  |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |   |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | <b>20a. ACCIDENT SUICIDE HOMICIDE</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |   | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) |  |   |  |  |
| <b>20c. TIME OF INJURY</b> Hour _____ Month, Day, Year _____  |  |   |   |  |   |  |  |
| <b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | <b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE   |   |  |  |
| <b>21. I attended the deceased from</b> <u>8-6-60</u> to <u>9-10-60</u> and last saw her alive on <u>9-10-60</u> .<br>Death occurred at <u>1:30 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.  |  |   |   |  |   |  |  |
| <b>22a. SIGNATURE</b> (Degree or title)<br><u>R. W. Bohm M.D.</u>   |  |   | <b>22b. ADDRESS</b><br><u>Brookfield Mo.</u>  |  | <b>22c. DATE SIGNED</b><br><u>9/12/60</u>                               |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>  |  | <b>23b. DATE</b> <u>Sept. 11, 1960</u>  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Bethel Cem., Anabel, Mo.</u>                           |  | <b>23d. LOCATION</b> (City, town, or county) (State) <u>Anabel, Mo.</u> |  |  |
| <b>24. FUNERAL DIRECTOR</b> ADDRESS<br><u>Wright Funeral Home, Brookfield, Mo.</u>  |  |   | <b>25. DATE RECD. BY LOCAL REG.</b> <u>9-13-60</u>  |  | <b>26. REGISTRAR'S SIGNATURE</b><br><u>Katharine Johnson dep.</u>       |  |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF..

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Harold B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).

- If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
- If this body is not embalmed, fact should be so stated above.